Contributors
US, JS, and SS were responsible for evaluating the antibody test; US wrote the first draft of the manuscript and did the epidemiological and statistical analyses; JS and SS contributed to the interpretation and discussion of the data and revised the different versions of the paper; NJ adapted the test method for dried blood samples and guaranteed the quality of the testing; MA created the structure of the data system and helped with the analysis of the data.

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U Steuerwald, J Sander, S Sander, N Janzen, M Andree
Neonatal Screening-Laboratory, Hannover, Germany

Correspondence to: Ulrike Steuerwald, Screening-Labor Hannover, PF 911009, D-30430 Hannover, Germany; usteuerwald@compuserve.com

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Chlamydia testing before termination of pregnancy

In Nottingham all women undergoing a termination of pregnancy (TOP) through the NHS sector are screened for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* and receive preoperative antichlamydial prophylaxis. Nottingham has a high level of both chlamydial and gonococcal infection, hence the need to include dual screening.

In order to maximise service capacity and provide sufficient access for women requesting a TOP some procedures are contracted out to external services such as the British Pregnancy Advisory Service (BPAS). Hence, we read with interest the paper by Mallinson and colleagues.[1]

In our service, to ensure that all patients receive a standard level of care, *C trachomatis* and *N gonorrhoeae* screening pre-TOP has been incorporated into the local NHS contract with BPAS. The screening is by nucleic acid amplification from a urine sample. A protocol for referring positive results to the local genitourinary medicine (GUM) clinic with the patient's permission is incorporated into the programme to allow follow up and partner notification.

Mallinson *et al* report that only 35% of women would have screening for *C trachomatis* if they had to pay a supplementary charge for the test, even if this was low, at 20, compared to the private cost of a TOP.

Identification and treatment of genital infection is key to good sexual health and although prophylactic antibiotic therapy will protect against immediate complications of the operative procedure it will not allow for contact tracing and avoidance of reacquisition, nor will it deal with the community pool of infection.[2] For areas with a high prevalence of *N gonorrhoeae* infection additional screening should be considered.

We believe that all services offering TOP, whether NHS or privately funded, should have screening, treatment, and a contact tracing plan incorporated into the procedure. The costs of screening should be included in the package and not be an optional extra. This is particularly important for women who, at a vulnerable time, may not be aware of the wider health benefits of screening.

P C Goold, E M Carlin
Department of Genitourinary Medicine, Nottingham City Hospital NHS Trust, Hucknall Road, Nottingham NG3 1PB, UK

Correspondence to: Dr Penny Goold, Department of Genitourinary Medicine, Nottingham City Hospital NHS Trust, Hucknall Road, Nottingham NG3 1PB, UK; pennygoold@aol.com

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Recent pilot studies of chlamydia screening

The recent pilot studies of chlamydia screening in Portsmouth and the Wirral show that there is a substantial burden of chlamydial infection in young women and that high uptake of screening and good coverage of the target population can be achieved.[1 2] This is important. However, the pilot studies do not demonstrate the effectiveness of chlamydia screening in reducing either morbidity or the prevalence of infection (nor were they designed to do this). In fact, further screening (in the recall study[3]) of the same target group in the same settings, approximately 16 months after the pilot screening had ended, shows no change in chlamydia prevalence: 11.2% (pilot) *v* 11.9% (recall) in the Wirral and 9.8% *v* 11.4% in Portsmouth. Opportunistic screening continued after the pilot in family planning clinics in the Wirral, but there has been no reduction in chlamydia prevalence (11.4% during March-August 2000 compared with 12.4% during March-August 2002).

It would be wrong to conclude that opportunistic screening does not work. The incidence of chlamydia in the United Kingdom appears to be rising and it may be that the prevalence found in the recall study would have been higher still in the absence of earlier screening and treatment. Thus, controlled studies are needed to determine effectiveness empirically. Economic modelling is important for assessing the long term effects of different screening scenarios but is of little value without reliable empirical data for which it cannot substitute.

The accompanying editorial[4] addresses important questions about screening men, screening in primary care, and asks "what further evidence is required before national screening for all at-risk groups?" Screening both sexes is clearly a more expensive, but potentially more cost effective, strategy than screening women alone. Since the vast majority of general practices outside the pilot areas are not currently involved in any organised screening programme, the ideal opportunity now exists for a randomised evaluation of different strategies to determine the most cost effective approach to screening in general practice.

In reality, any screening programme in general practice would take considerable time to be introduced on a large scale. Phased introduction in the context of a randomised trial poses no ethical problems because the optimal approach (for example, women or both sexes? opportunistic or cyclical?) is unclear and no strategy has yet been shown to reduce chlamydia prevalence or morbidity in the United Kingdom.

We propose a trial in which general practices would be randomised to screening young women alone, screening young men and women, or to no defined screening programme. Effectiveness would be determined by comparison of chlamydia prevalence or associated morbidity across the three arms at follow up. Such a trial, combined with an economic evaluation of the different screening strategies, would provide the direct, robust evidence that is currently lacking but essential to achieve effective control of chlamydia in the United Kingdom through wise use of resources.

J Stephenson, J Hopwood, A Babiker, A Copas, M Vickers
Department of Sexually Transmitted Diseases, UCL Medical School, The Mortimer Market Centre, Off Capper Street, London WC1E 6AU, UK

Correspondence to: Dr Judith M Stephenson, Department of Sexually Transmitted Diseases, UCL Medical School, The Mortimer Market Centre, Off Capper Street, London WC1E 6AU, UK; jstephen@gum.ucl.ac.uk

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NOTICES

7th European Society of Contraception Seminar

An ESC seminar entitled: "Contraception practice in Europe: differences in availability and accessibility" will be held in Budapest, Hungary, on 12–13 September 2003.
Further details: ESC Central Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: 32 2 582 08 52; fax: 32 2 582 55 15; email: esccentraloffice@contraception-esc.com and website: http://www.contraception-esc.com/).

8th European Society of Contraception Congress

The 8th European Society of Contraception Congress will be held from 23-26 June 2004 in Edinburgh, Scotland, United Kingdom. Further details: ESC Central Office, c/o Orga-Med Congress Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: 32 2 582 08 52; fax: 32 2 582 55 15; email: orgamed.ann@pandora.be and website: http://www.contraception-esc.com/edinburgh.htm).